NOVEMBER 1957

A PSYCHIATRIC WORD CLINIC

MANAGEMENT
AND THE NURSING DEPARTMENT

SHOULD STATE HOSPITALS
STAY IN THE FARMING BUSINESS?

PLANNING A DORMITORY UNIT
FOR THE MENTALLY DEFICIENT

Mental Hospitals

American Psychiatric Association

Mental Hospitals

Volume 8
Number 9

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Published monthly, 10 times a year, September through June, for staff members of mental hospitals, schools and related institutions which subscribe to the American Psychiatric Association Mental Hospital Service. Subscription price: At the rate of $2.50 a year each, up to 15 copies of each issue are included in the dues of $50 a year for institutional subscribers to the Service. Individual subscription rate (for staff members of subscribing institutions only) $2.50 a year. Limited-service dues of $15.00 a year for related professional organizations and mental hygiene societies includes 5 copies of each issue at the rate of $2.50 a year. Published by the American Psychiatric Association Mental Hospital Service, 1785 Massachusetts Avenue, N. W., Washington, D. C. Entered as Second Class mail matter, August 1st, 1952, at the Post Office, Washington, D. C., under act of March 3, 1879.

INSTITUTE HIGHLIGHTS

The Ninth Mental Hospital Institute, held in Cleveland, Ohio, from September 30 to October 3, drew 467 delegates from 45 states and the District of Columbia and five Canadian provinces plus a distinguished visitor from Australia, Dr. E. Cunningham Dax, Director of Mental Hygiene for the State of Victoria.

Our cover picture shows Dr. Daniel Blain, A.P.A. Medical Director, congratulating representatives of the hospitals which won the 1957 Achievement Awards. From left to right they are: Dr. Viggo W. Jensen, clinical director of the Detroit (Mich.) Receiving Hospital, winner of a silver plaque and first general hospital to receive an Award; Dr. Ott B. McAtee, superintendent of Madison (Ind.) State Hospital, which received an Honorable Mention Certificate; Dr. Charles H. Jones, superintendent of Northern State Hospital, Sedro-Woolley, Washington, which also received Honorable Mention; and Dr. Ian W. Clancey, clinical director of the Saskatchewan Hospital, Weyburn, Canada, to which a silver plaque was given.

Of the 467 persons attending, there were 245 physicians, about 85 business managers and other administrative personnel, 45 nurses and 20 social workers, with the remainder from various other disciplines and related agencies. Ohio, as the host state, of course had the largest representation with 40 persons; Indiana had 35; New York had 30 and Pennsylvania and Michigan each had 27.

The Academic Lecture, on "Principles, Skills and Tools of Scientific Management," was delivered by Professor James L. Hayes of St. Bonaventure University, N. Y., who was introduced by Dr. Addison M. Duval.

In his presidential address* on the historical development of mental hospitals, Dr. Harry C. Solomon said that the present system is already outmoded and must be revamped to meet the challenges of the developing trend toward treatment outside the traditional mental hospital setting.

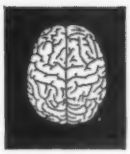
Dr. Solomon presented a special A.P.A. citation to Judge David L. Bazelon, of the U. S. Court of Appeals for the District of Columbia. The citation honors Judge Bazelon for his several decisions which have promoted better understanding between psychiatry and the law. These rulings, which include the famed Durham Decision, lay down the principle that an accused person is not criminally responsible if his unlawful act is the product of a mental disease or defect; thus his accountability is based upon his emotional rather than his intellectual capacity. In his acceptance speech* Judge Bazelon noted that the testifying psychiatrist "need not and, indeed, should not employ terms which he thinks are meaningless or inaccurate. . . . He must try to make his testimony useful to those who must make the decision. But at the same time he should present his data in language which is medically sound."

The optional meetings included a session for business managers, a meeting of state mental health commissioners, one of nursing consultants, and an architectural presentation of the Children's Psychiatric Hospital being constructed in Dayton, Ohio.

The local hospitals visited on the "free afternoon" were the Cleveland Receiving Hospital, Cleveland State Hospital, the Howard M. Hanna Pavilion of the University Hospitals of Cleveland, and Ingleside Hospital and Farm.

The proceedings of this Institute will be published in the February 1958 issue of MENTAL HOSPITALS. Copies will be sent to all persons who attended.

**Full text will be published in the Proceedings*



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References:
1. Sainz, A.: Personal communication.
2. Hutchinson, J. T.: Evaluation of Pacatal in Psychotic States, address before the American Psychiatric Association, Nov. 16, 1956.
3. Bowes, H. A.: Am. J. Psychiat. *113*:530 (Dec.) 1956.

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PROFESSIONAL Feature Of The Month

A Psychiatric Word Clinic

Semantic diagnosis and analysis in four sessions

The author shows how to help your chosen words best perform their life work, that of describing the patient and his problems with precision and nicety, thus making the hospital chart a lively and vivid document.

By HENRY DAVIDSON, M.D., Superintendent
Essex County Hospital, Cedar Grove, New Jersey

OURS IS A WORDY SPECIALTY, for we deal essentially in disorders of communication. In understanding patients, and in conveying that understanding to others, we have one major tool: the word. And what we write on a hospital chart is immortal. A decade from now, someone will send for the chart and try to conjure up a picture of a human being with only our words as messengers. If we use words with precision, we will create a vivid and accurate picture of the patient. If we use the general word which first comes to mind, we will leave a blurred and misleading record behind us.

Consider the patient before you. You know what he is like, but this is not enough. You must be able to crystallize that knowledge permanently into a record. To do this you must choose the right word, the precise word, the word that happily fits the facts. You must not use a feeble word when a vigorous one is needed, or a general term when you want a sharp one. For example, there is a spectrum of **confusion** from "bewildered" through "perplexed" to "distracted". The **bewildered** patient has a sort of numb apathy about his confusion; the **perplexed** patient feels unsure of how to act, but it is not simply numb apathy, while the **distracted** patient is agitated about it. So you must, like an artist with a large palette, choose the right tint for your verbal painting. Confused, bewildered, perplexed or distracted? Which is the happy word that most faithfully portrays this patient?

Words have a history, sometimes literally spelled out in their present form. And as with men, the past throws light upon the present.

See the wilderness in "bewildered". A wilderness is a waste, a trackless, pathless waste. When you are in a wilderness you don't know where to turn because one way is as good as another. **Bewildered** then means "lost in a wilderness". By contrast, examine the word **distracted.** Its Latin forebear *trahere* means to pull or draw; "distracted" means "pulled apart". A distracted person is agitated—pulled every which way. The bewildered patient, on the other hand, is stalled, almost paralyzed. Between these poles is a colorful range of adjectives. "Confused" is a feeble one when you consider the rich reservoir of precise available terms.

Humpty-Dumpty mastered words by paying them extra—and made them mean just what he chose them to mean, neither more nor less. But our mastery must be more subtle. We have a mastery of words only when we know two things:

(1) In what specific way one word differs from words of similar meaning; (2) why it means what it does. Etymology helps understanding; when you visualize the word "wilderness" inside of the adjective "bewildered" you gain insight into the word. Or take the adjective "confused", which shares a common ancestor with "funnel". Confused means poured in together or mixed up—everything mixed up that should be separate.

The words we may use to describe a patient fall into six main categories plus a group of general words. The first category expresses SADNESS:

Blue; cheerless; dejected; depressed; despairing; disconsolate; disheartened; dismal; downcast; dreary; forlorn; gloomy; grave; grim; lugubrious; melancholy; pensive; sad; solemn; woebegone.

Next in contrast, words expressing HAPPINESS:

Blithe; convivial; debonair; ecstatic; elated; euphoric; exalted; expansive; grandiose; happy; hilarious; jocose; jolly; jovial; jubilant; merry.

The third category contains words expressing IMPULSIVENESS AND IRRITABILITY:

Agitated; automatic; circumstantial; delirious; flight of ideas; fractious; impulsive; instinctive; irritable; mechanical; peevish; spontaneous; querulous; testy; verbigeration.

Words expressing BIZARRENESS come next:

Abnormal; absurd; autistic; bizarre; dissociated; eccentric; fatuous; foolish; hebephrenic; idea of reference; irrelevant; mannerism; irrational; paranoid; peculiar; preposterous; silly; singular; strange; unreasonable.

Back to our friend CONFUSION:

Addled; ambivalent; bewildered; chaotic; confused; clouded; confabulatory; dereistic; disoriented; distractible; incoherent; paramnesic; perplexed; preoccupied.

And finally, words of WITHDRAWAL AND INDIFFERENCE:

Aboulia; apathy; catatonic; comatose; decadent; de-

generated; deteriorated; depersonalized; demented; dull; evasive; flat; mute; negativistic; passive; seclusive; shallow; slovenly; stereotyped; stuporous; untidy.

The general grouping includes words which reflect whole categories of psychiatric concepts—the main words being:

Affect; anxiety; insight; judgment; neologism; psychosis; sensorium; tension; trend.

Since the art, at least, of psychiatry, is based upon these few concepts, it might be well to admit these first of all to our word clinic. Once we are assured that these words are free from flaw, defect or decay, we can consider the more personal and specific terms which are the backbone of our psychiatric lexicon.

GENERAL CONCEPTS

Affect is mood or emotion. It derives from the Latin words *ad* plus *facere*, literally "to make upon"—that is, to do something to someone. Affect does something to us. It is, in a way, the subjectively experienced effect of an emotion. Anger or rage, for instance, is an emotion, in that it "moves" us. The sense of pain or pleasure is "affect". The essence of affect is that it is experienced inwardly. **Flattened affect** will be considered under "words of withdrawal or indifference".

Anxiety is a poorly grasped fear without apparent cause. It is a sense of impending danger, an inner dread, an anticipated harm. Typically, anxiety seizes the consciousness, and colors or dominates it. Anxiety means tension and disquiet. The etymology of the word is interesting. It is akin to anger, anguish, angina and quinsy. *Angere* in Latin means "to strangle", and angina, anxiety and anger all come from this. *Anchein* is the Greek cognate, also meaning "to strangle". *Kyn* is the Greek for dog; kynanche means dog-collar. Quinsy is derived from kynanche (meaning "choking sensation").

"The question is, whether you *can* make words mean so many different things."

From *Through the Looking Glass*
by Lewis Carroll

Insight and **judgment** are the two most abused words in hospital psychiatry. Insight is a patient's realization of the severity and general nature of his emotional (or mental) disturbance. The word means "to see within", the implication being that the person can see the inner essence of things. He sees the "inside" of his own illness. For a patient to have insight, he need not necessarily know the dynamics of his symptoms. It is enough if he really *accepts* the fact that he is emotionally ill. *Knowing* that he is ill is not enough. He must *accept* it. Insight may be superficial or partial. A patient has *partial insight* if he knows that certain of his ideas are delusional, or that some of his symptoms are emotionally rooted. If he sees why people consider him mentally ill, but he cannot accept this evaluation, the insight is *superficial.*

Judgment comes from two Latin words *jus* (the law) plus *dicere* (to say). Judgment is to "say the law"—that is, to pronounce what is correct. (In French and German, the word for "right" is also the word for "law".) Judgment is the ability to compare facts or courses of action and select the better action or the truer fact. Of course, "better" and "truer" are themselves subjective evaluations, and depend, often, on the examiner's personal philosophy. Is it good judgment for the son of a wealthy businessman to become a missionary? Obviously this depends on the critic's evaluation of "good". Judgment implies the ability to see both courses of action or both sets of presumed facts, to compare, weigh, ponder, and make a selection which the "average" person would endorse. Implicit in judgment is a critical testing, an ability to see the good and bad features of each possible course. A patient can be said to have "poor judgment" only if there is a different generally accepted action or interpretation which most people would say is "right". Otherwise the patient's judgment may be different from the examiner's without being "poor judgment".

A **neologism** is a word invented by the person who is using it. The term might be extended to cover peculiar or special meanings which a patient gives to a familiar word. The Greek words *neo* and *logos* mean "new" and "word" respectively.

To the lexicographer, a **psychosis** is any mental disorder. By popular agreement among psychiatrists, however, the word is reserved for severe disorders. Usually, "psychosis" is considered the medical equivalent of the legal term of "insanity". Thus, the American Psychiatric Association's "official" definition (as reported in that Association's PSYCHIATRIC GLOSSARY) is:

"Psychosis: A severe emotional illness in which there is a departure from normal patterns of thinking, feeling, and acting. Commonly characterized by loss of contact with reality, distortion of perception, regressive behavior, diminished control of impulses . . . abnormal mental content. . . . Personality deterioration may occur. May require commitment to a mental hospital."

This is a definition of insanity. The lexicographer here has equated psychosis and insanity. This is common usage among American psychiatrists. *Psyche* is Greek for "mind" (originally, indeed, for "soul"). The suffix—*osis* means a "condition of" as in sclerosis or

for the depressed and regressed

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nephrosis. The first word in the phrase "psychic research" uses the primitive meaning of *psyche* as "soul"; defining "psychiatrist" as "mind physician" illustrates the modern use of *psyche* as "mind".

Sensorium is the patient's awareness of his surroundings. The Latin *sentire,* from which it derives, means "to perceive". A defect in the sensorium is practically the same as "disoriented". At one time, it was thought that the human animal contained three operating centers, corresponding to autonomic, sensory and motor nerves. These were known as the vegetorium, the sensorium and the motorium, respectively. The first and last terms have become obsolete. The word sensorium, though less frequently used than formerly, still remains. It may be equated, broadly, to "consciousness of surroundings". Sensorium may be characterized as "clear" or "clouded" as "intact" or "damaged".

The Latin word *tendere* means "to stretch". Hence **tension** is a sense of being stretched, of being taut, of being ready to snap like an over-extended string. The word tension is used clinically to describe a state of uneasiness due to an uncomfortable expectancy of trouble. In tension, the patient feels ready to explode now—giving the impression that the next irritant or frustration is the last straw. In **anxiety** (see above) the sense is one of *impending* danger—something that will happen tomorrow.

Trend of thought is a paragraph heading on many hospital records. Trend is a constellation of ideas, or a direction towards which the patient's thinking leads. A delusion may dominate the trend, for instance, so that all his thoughts lead to a reconfirmation of his despair, his hope, his sense of grandeur, or his sense of grievance, according to the nature of his delusion.

Now let us bring into our Word Clinic the six groups of words listed above. We will base our "group-therapy" upon their similarity of behavior!

WORDS OF SADNESS

The unimaginative examiner simply writes: "The patient is depressed." But this is a listless way of saying it. We have a wonderful variety of adjectives to express the nuances of depression. We may say the patient is pensive; dejected; disconsolate; gloomy; grave; grim; depressed; despairing; disheartened; grief-stricken; melancholy; woe-begone. With so colorful a palette, it is unnecessary to limit oneself to a colorless word like "depressed."

Perhaps "colorless" is the wrong word here. Actually, "depressed" is often identified by a color: *blue* is a sad color, a dark color, the color of death. The color of illness is bluish, ashen, livid. People in delirium tremens see blue devils and that (says Oxford) is what the word "blue" comes from. Webster reports, however, that it comes from the quality of the color itself. The contrasting color with blue is always given as red. Red is associated with cheerfulness, happiness, brightness, and warmth.

When the patient has the "blues" he is not as depressed as one who is "dejected." Blue is a subjective recognition of being depressed. It is a legitimate English word, however—not slang.

What type of music is "the blues?" Music in a minor key. The St. Louis Blues or the Basin Street Blues—what does the word "blues" in those songs mean? Mournful or melancholy.

Melancholy originally meant a predominance of black bile. In the song "My Melancholy Baby," the implication was not that she was sad or unhappy. The adjective "melancholy" meant she was cynical and suspicious of people's motives. There is in the word "melancholy" an implication of detachment. It includes the ability to look at the world and say it is in a bad way. "Melancholy" is rarely used by a psychiatrist. **Melancholia,** however, has a specialized meaning, referring specifically to the depressed phase of a manic depressive psychosis. The word has even been removed from the involutional psychotic reaction.

Cheerless is from the Latin *cara* for "countenance." The phrase "be of good cheer" means, literally, "be of good countenance." In theory, cheer can mean bad cheer as well as good cheer but in usage, cheer always means "good countenance," not bad. So *cheerless* means devoid of mirth or gaiety.

The shop-worn adjective **"depressed"** has become common currency. Literally it means "pressed down." The ordinary non-medical dictionary sees three elements in depression: sorrow, brooding and diminished vigor, but we do not, in psychiatry, require "diminished vigor," in a physical sense, as a component of depression.

Dejected means "cast down" (*jacere* "to throw") and implies some force—presumably external. For example, the patient is dejected by reason of bereavement or failure to win a promotion. These are external factors.* Contrast this with a situation where, out of the inner recesses of his mind, a patient conjures up a sense of sin rooted in the memory of a childhood peccadillo by which he is now doomed. Here, presumably, is depression from inner forces as contrasted with dejection due to external difficulties.

Downcast is, substantially, the same as dejected and is exactly the same as its literal meaning: thrown down.

Despairing is a handy word. Its origin reveals its meaning. The "de" is common to many of these words —it means "down" (dejected—literally downcast.) *Spero* means "I hope." "Despairing means deprived of hope, hopeless. The despairing patient is the one who has given up hope.

"Solace" is hidden in the word **disconsolate,** which means "not to be consoled." In "despairing" the emphasis is on the abandonment of hope; but "disconsolate" emphasizes "not to be consoled."

Disheartened literally means "without heart"—not in the sense of "heartless" but in the sense of "discouraged." Actually these two adjectives are identical, since "dis-

* *Of course these external factors operate by triggering some factor within the patient's mind—but these words portray the appearance, not the inner reality, of the depression.*

couraged" comes from *coeur,* the French for "heart." "Courage" is hidden in both words.

Dismal is *dies mali*—bad days. You do not say that a patient is dismal. But you might say his thoughts are dismal or his preoccupation is with dismal ideas. "Dismal" is associated with disaster; black Friday, a bad day. When you speak of the patient as having a dismal thought, he has a thought of disaster.

Now, suppose you say the patient is in a dreary mood. What is the peculiar implication of the word **dreary** as distinct from these other words? It means gloomy, comfortless, unattractive.

The word **distress** is from *stringere,* from which the English word "string" is derived. It means in Latin to "draw tight." To be distressed is to suffer a strain, to be pulled apart. (The useful prefix "de" or "dis" implies "separation" here.) "Distress" is more general than "anguish" because the latter has the implication of torment, though it is weaker than "agony," which implies a more severe kind of pain. "Distress" may indicate either physical or mental, or for that matter, financial embarrassment. A person can be in distressed circumstances. In psychiatric jargon, **distracted** means being worried because you are pulled in several directions at once. The word "traction," to drag, is much stronger than *stringere,* to pull. Hence, "distracted," which carries within it the word "traction," is stronger than "distressed." "Distress" lacks the high degree of agitation found in "distract." Or to put it in another way, it is possible to be quietly distressed. It is not possible to be quietly distracted. "Distress" means worry because you are being pulled in several directions at once, not with the benumbed feeling of bewilderment nor with the agitation of distraction, but rather with embarrassment. **Distressed,** therefore, is a word that can be used with considerable accuracy.

The German word *verleren* means lost. The English analogue is **forlorn.** Forlorn means "lost" and it is used in psychiatry to indicate the mood of a patient who feels abandoned, neglected or forsaken. It is a colorful word which we would use more often if we thought of it.

Gloomy describes a mood or a point of view. A patient's view is gloomy. The term is analogous to the word "glower" and it stems from an old Gothic word which means "to make dark." It has an implication of darkness and pessimism. We speak of the patient's mood or the mood he produces in others or the emotional environment which he generates as "gloomy."

The word **grave** does not imply sadness or melancholy. It is from the Latin *gravis* (heavy). It means solemn, serious, sedate and somber. "Grief" has the same origin as "grave" but it comes through the aspect of the word which means a place for the dead. Both words have the same source, meaning bereavement, therefore, grief, hence, mental suffering. It has been extended in modern English to indicate suffering from remorse as well as suffering from bereavement. Hence, the "grief-stricken" patient may suffer from remorse *or* bereavement. It is a more active word than "gloomy" because in it is the element of actual bereavement.

In the same general class is the little used word **grim** which derives from the same source as the word "chagrin." Originally it meant cruel, merciless or savage. From this it has come to mean stern and unyielding and finally, in its modern usage, stiff and exacting. It suggests harshness, bitterness or savage mercilessness. Use the word "grim" to describe a delusion or a trend of thought rather than to describe a patient.

This word "grim" which once implied all of this bitter savagery is now used so casually that the patina is rubbing off. This is the fate of many words; "rugged", for instance, has gone through a similar shift and suffered a blurring of meaning. Such words are like worn coins; dropped into the reader's consciousness, they no longer operate to produce the neatly packaged thought he had the right to expect.

The common word **sad** has also lost specificity, except in the passive sense of reflecting unhappiness over some one else's misfortune. "I was saddened to hear of his death," implies not that I was overwhelmed with grief, but that I am sorry for the survivors. It originally meant "sated"; filled-up, worn, weary, having nothing to look forward to. It came from *satis*—meaning "enough", as in "satisfied." Now it has come to mean "one who is sorry because he has tasted every experience life has to offer." He is "sated." And by extension, from "sated" in this sense to "disgusted," to "dreary" and eventually to "dissatisfied."

In Latin, **lugubrious** meant "mournful." Curiously, it has now come to suggest pretense, or sham mournfulness, or exaggeration. It lacks the implication of sympathy which you find in "grief-stricken." If you say that the patient seemed lugubrious, you hint at something sham about his mournfulness. Hence, the word has limited usage.

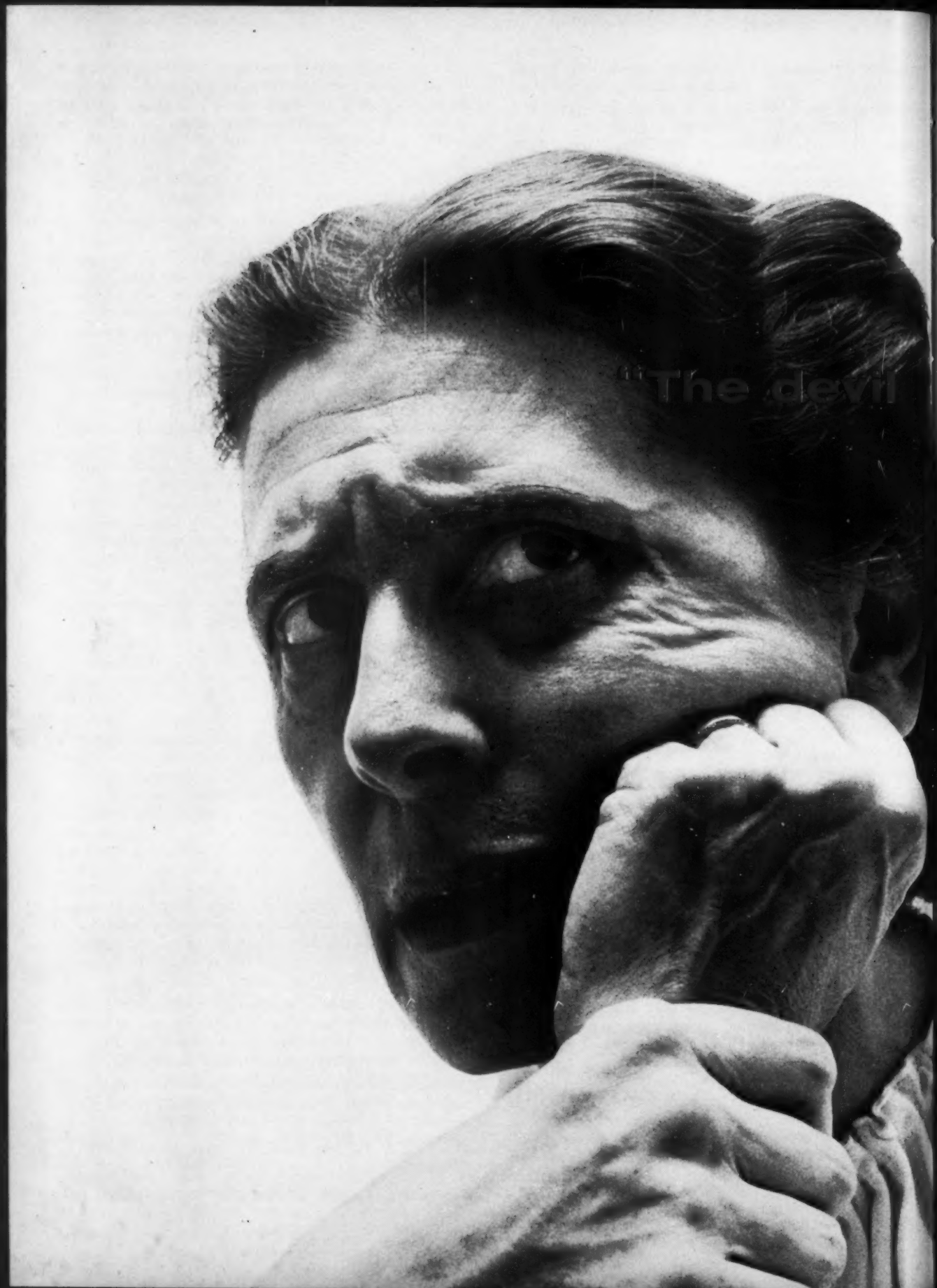
Pensive comes from the same source as "weigh"; it means to ponder which also means "to weigh." (Pound comes from the same root.) "Pensive" therefore, means thoughtful in the sense of weighing things. A wistful dreamy thoughtfulness approaches melancholy. You speak of the patient as being pensive, not in the sense that he is in psychic pain, but in the sense that he is worried about conditions; he broods about them. It is not catatonic withdrawal; it is not daydreaming; rather it is a brooding concern about the sad state of the world and what can be done about it. Milton's two poems "Il Penseroso" and "L'Allegro" were intended roughly to represent the pessimist and the optimist. Il Penseroso was, of course, the pensive one.

The word **solemn** comes from the Latin words *sollus annus,* recurring annually. It implies ritual or ceremonial. "Solemn" means more than "grave"; there is an added element of impressiveness or ceremony.

Woe is the cognate of the German *Weh*: a miserable affliction. So our little used but colorful phrase "woebegone" describes a patient who seems immersed in his afflictions.

* * *

Session II, next month, will deal with "High-Pressure" words.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1. Fazekas, J.F., et al.: J.A.M.A. *161*:46 (May 5) 1956.

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No. 2 in a Series

MANAGEMENT AND THE NURSING DEPARTMENT

By ALICE M. ROBINSON, R.N., M.S.
Director of Nursing Education, Vermont State Hospital, Waterbury

On reviewing the fundamental principles of modern scientific business management, we recognize that such principles can, in general, be applied to the nursing service and nursing education departments of our large public mental hospitals. One prodigious and awesomely realistic difference between a hospital and an industrial organization is apparent however: that the object of our endeavors—the patient—is a *human being*. We work not with machines but with ourselves and, for the nursing department more than any other service, the work is a continuing process. We cannot "shut down the shop" at the end of the day nor at the end of the week.

The primary aim of each group of workers from the administrative hierarchy down through nursing, maintenance, housekeeping, and so on, is to provide good care for patients. With this aim in mind each group attempts to pave the way leading from the hospital community into the communities outside of the hospital.

The laboratory technician, plumber, and others up to and including the physician must be "on call" through the night and on weekends for an emergency. It is impractical to suppose that the nursing service could operate similarly. This necessity for unbroken continuity of service makes the nursing department more vulnerable in respect to management problems.

So far, in the process of improving nursing education, "management techniques", as such, have been neglected. Increased interest in administrative psychiatry for physicians, however, may provide the impetus for research into the particular management problems of the nursing service. A few years ago, when I was a nursing service administrator in a large mental hospital, a magazine editor asked me a thought-provoking question: "Of the many administrative problems that are particularly yours, which one consumes the major part of your time?" The answer was not difficult. "The individual problems of personnel." Because of the inherent problems peculiar to the nursing care of patients, a "personnel director", though helpful, does not obviate the fact that the nurse-administrator must be proficient in counselling techniques, diplomacy, and liaison skills. How, for example, can we avoid an attitude of "hopelessness" among nursing personnel who are so frequently faced with the gross, the raw, the sometimes irretrievable mental illnesses?

Specific Principles

Dr. Addison M. Duval has outlined certain basic principles which can be applied to all management. "All management" can include, with some modifications, nursing administration.

Objectives: Establishing objectives for nursing personnel is essential, and should be considered not only in terms of overall planning, but also in specific ward planning and individual patient planning. Such objectives are sometimes not immediately perceived except through "trial and error", but because trial and error is an expensive process, some overall goals must be set. Such goals should be the result of *combined* planning on the part of the higher echelons and the "bedside corps". Not only can the goals be set by such *shared* planning, but their implementation can be thought out and set into motion.

Economy of planning can be accomplished by establishing committees on procedure, personnel grievances, in-service education, etc. Representation on such committees should be all-inclusive (supervisors, psychiatric aides, staff nurses, instructors) and the good nursing administrator will find it advantageous to invite members of other departments which may be particularly concerned. At first glance, this would seem to involve considerable expenditure of time on the part of the nurse-administrator, but, in the long run, time which would otherwise be spent in *individual* and *specific* wrangles can be gradually eliminated. The "busy" nurse-administrator should not allow numerous meetings to interfere with the schedule of patient and employee contact. Once such a "committee system" is set up, administrative nursing representation on each committee can be delegated. Nowhere can one wheel carry the load!

Delegation of Responsibility and Authority: Delegation of responsibility and authority in the nursing department is essential because of the limited human resources with which we must work. Personnel shortages in mental hospitals have been incredible in the past, and, even though improved, must still be considered acute. In order therefore to avoid the pitfalls of work haphazardness, low morale and rapid turnover (the three undermining headaches with which a nurse-administrator must live!) authority and particularly responsibility must be clearly delegated. The chief danger lies where, many times, we assign the responsibility without corresponding authority—and without proper reward! The nurse-administrator in a "tough spot" places a nurse or aide in complete charge of a ward or unit simply by issuing the order. As a temporary measure, this might be acceptable if there are good and satisfying working relationships. But too often, alas, the "assignment" goes on for such an extended length of time that the situation becomes intolerable and frustrating to the unhappy employee and he leaves. This is by no means entirely the fault of the nurse-administrator who may not have a "bloc" or

"position" of higher reward to offer. The solution to this problem lies in the combined determination of the nurse-administrator, the superintendent, and whatever group controls the budgetary problems in any particular hospital.

SUPERVISION: "We now believe that good immediate supervision is a requirement for successful operation, but we still give too little attention to the supervisors' training for supervisory duties," writes Dr. Duval. The nursing profession has too long labored under the handicap of a distorted preconception regarding the term "supervisor". A supervisor has, unfortunately, come to be regarded as a "boss" who "sits in the office and struggles with paper problems". Supervision, in its most dynamic sense, means *guidance*. Inadequate, disinterested nursing supervision has for years been a crippling factor in the nursing departments of mental hospitals. In the beginning there was excuse for this, because the task of supervision, if not almost entirely neglected, had to be assumed by persons totally unprepared for it. The professional registered nurse, when she did appear on the scene, was such a rarity that her very appearance aroused resentment (based on fear) and resulted in dissension and confusion among the ranks. Such a viewpoint has gradually diminished as nurses, for the most part, have been able to demonstrate their specific aptitudes in caring for mental patients.

The problems of inadequate and disinterested supervision still exist, however, and various methods have been tried in an endeavor to alleviate them. Foremost among these is inservice education, but a lack of interest in the didactic phases of such a program has made it more or less ineffectual. An inservice program for supervisors and head nurses should be geared rather emphatically toward the *clinical area* and should include not only a good deal of "action instruction", but also attendance at staff conferences and research meetings, with an active chance at *participation*. Such a program should be, if not actually compulsory, included in the job description or job "requirements" presented to the nurse prior to employment.

Ideally, an inservice programs for professional nurses should be a specific responsibility of the nursing education department. One instructor should devote her full time to this neglected but essential function. Realistically, few nursing education departments have a sufficient number of faculty members for such planning. For the most part, instructors have had a heavy enough work load in providing programs for affiliate student nurses and psychiatric aides. Concerted follow-up *on the wards* is of the utmost importance, yet such follow-up, both with affiliates and aides, consumes a considerable amount of time.

TOOLS OF MANAGEMENT: Dr. Duval has listed 13 tools of management. In direct relation to *nursing* administration, the following are selected as presenting serious problems: Personnel Selection Techniques; Personnel Utilization Techniques; and Communication Systems. Previously mentioned personnel shortages are and have been, for a long time, responsible for the lack of essential **personnel selection techniques.** This has proved a costly error, and has resulted in rapid turnover within the nursing service. Some progress has been made through improved orientation programs, but other methods are available for use in screening prospective nursing employees. The nurse-administrator can study such available methods and utilize those most applicable in relation to her particular situation.

"Personnel utilization techniques" suffer from the same malady as personnel selection techniques—namely, personnel shortages. When a vacancy occurs, the nursing-administrator is faced with the immediate problem of replacement without ample time to consider the capability, preference, and suitability of the person used to "relieve". These are the realities, and until we have sufficient human resources, we simply cannot apply known selection and utilization techniques.

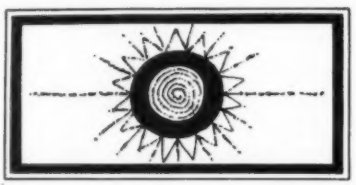
Communication Systems: Psychiatric nurses have come to know and accept the fact that communication is the most valuable tool in nurse-patient relationships. The nurse-administrator knows, too, that the theories which have been developed in this all-important area, can and must be applied also to nursing management. Nursing departments in mental hospitals have been incapacitated by "tradition" and the inability on the part of large groups of nursing employees to accept *change*. An extravagant waste of time and energy is expended in the effort to make changes "democratically". The horns of the dilemma are apparent. On the one hand it is expedient to make changes; on the other is the awareness that, in the long run, changes should be made through group planning and participation. Frequent and thorough communication throughout the nursing department can accomplish much in dispensing with this dilemma.

The problems of the nursing department in a mental hospital are immense and numerous. The five major nursing problem areas outlined here should be the basis for considered and energetic attempts on the part of the nurse-administrator to apply certain of the principles of industrial management toward the improvement of nursing care for the mentally ill.

Nursing Education Department Offers Special Instruction

Special referred clinical instruction is now available to all nursing personnel at the Osawatomie (Kansas) State Hospital, on either an individual or a group basis. A mimeographed form is used to request the service. For instance, if a new procedure is to be started in the Tuberculosis Unit, an instructor from the Nursing Education Department plans with the supervisor a special class in order to prepare personnel before the procedure is started. If an aide in a certain building is to perform a procedure with which he is not familiar, an instructor from the Nursing Education Department will go to the service and supervise the task. This instruction is not limited to nursing arts procedures. It may include any aspect of psychiatric nursing such as the application of a specific attitude of an employee toward a patient. This program has been of great value in providing safer and more effective patient care.

MRS. DORIS TROBAUGH, Director of Nursing Education



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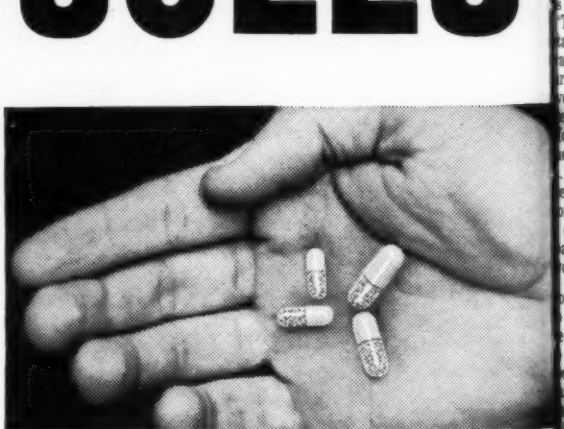

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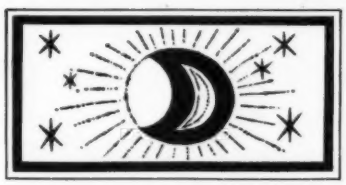

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THE FOSTER HOME COTTAGE –
A New Approach to Discharge

By PETER A. PEFFER, M.D., Manager
and J. FREDERICK GLYNN, M.S.S.W., Chief, Social Work Service
Veterans Administration Hospital, Brockton, Mass.

TWO GROUPS of mental patients still challenge the best efforts of the hospital team to return them to the community—and keep them there. These are the patients, hospitalized for many years, who are well enough to return to the community, yet who have no homes or relatives to return to or have relatives who are unwilling to accept them.

The help we must give these patients, who make up the greatest portion of the patient population in the typical mental hospital, must motivate them to desire release to a community where they may live in a happy and dignified manner.

Hundreds of years ago, long before the building of large mental hospitals, foster home care for the mentally ill was instituted. This method most closely approximates normal life in one's own home in one's own community. Since the home is the basic unit of society it is within this framework that man is happiest. It is to a home in the community, his own or a foster home, that the patient should be released to receive the benefits implicit in a home setting.

Soon after the foster home program was inaugurated here, our social workers found that their techniques in motivating patients to try a foster home were severely handicapped by the hospital setting. The patients were convinced they were sick; in spite of their day-by-day performance, they were certain they required hospital care. Other patients would advise them, "You don't want to leave here; this is a wonderful place; you've got it made!" Relatives, too, emphasized that the patient should not leave the hospital where there was so much for him; after all he had been hospitalized for 10, 15, 20 years—what could he do on the outside? Who would want him? Who had room for him?

To meet these challenging problems, we felt that if we could show the patients what a foster home was like they would be willing to try one. We thought, too, that if relatives saw their patient in a home atmosphere they might take him into their own home, if they had room, or would at least lend support to foster home placement.

With these ideas in mind we set up the "Foster Home Cottage" on the grounds of the hospital. This is a small, ten-room cottage formerly occupied by nursing assistants, which was redecorated to suit its new use. Each patient has his own bedroom and his own closet where he may keep all his clothing and belongings. The bedrooms are cozily furnished with maple furniture, an easy chair, bedside table, rugs, and an afghan on each bed. The living room, which also serves as a dining room, is a comfortable room in the New England tradition, complete with cafe curtains and a parakeet.

Soon after the program got under way it became apparent that the men required a hobby shop in the Cottage. Bedrooms are not satisfactory places for carrying out such hobbies as painting, radio repair, etc. and the combined dining-living room cannot serve as a hobby shop. A fine shop was accordingly added in such a manner that it enhanced the overall design of the building.

A foster mother and a foster father were needed. No doctors, nurses, or uniformed aides were to be assigned since we wanted to avoid the hospital atmosphere. A female aide, who had been a foster mother prior to her employment at the hospital, was assigned. The foster father was selected from the Member-Employee Program;* he is "the man about the house."

All services and divisions in the hospital helped to make the Cottage a real home. Carpenters, plumbers, electricians, and painters were busy. The dietitian planned the kitchen and the method of obtaining food, and taught the foster mother how to teach cooking to the patients. Volunteers purchased items not provided by the VA but which were needed to make the place homelike.

Patients Adapt Quickly

On February 1, 1956, newly installed door chimes announced the visitors to the first "Open House"; patients selected to live in the cottage acted as hosts. They helped with the serving of tea and cookies which, incidentally, they had helped to prepare. There was light, gay chatter—and the change in these ten patients could already be noted. Two weeks before these men had been fearful at the thought of leaving the hospital; now they were entertaining employees from all over the hospital, and talking about the cottage and the idea of moving into a foster home. The first step had been taken; the hospital atmosphere had been abandoned; patients with a common goal were living together and were talking about leaving.

By the end of the first week the early excitement had disappeared; in its place was a warm, easy camaraderie. The men enjoyed eating "family style". They did not mind being instructed in good table manners by the foster mother, a warm, friendly woman who is always neatly dressed in an attractive print dress and apron. Each patient assigned himself a task around the house which was to his liking: setting the table, helping with

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* *Peffer, P. A. Money: A Rehabilitation Incentive for Mental Patients. Amer. J. Psychiat., 1953, 110, 84-92. Member-Employee Program—A New Approach to the Rehabilitation of the Chronic Mental Patient. A collection of 27 papers published by staff at VA Hospital, Brockton, Mass.*

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the cooking (this, at first, was supervised by a dietitian), washing the dishes, sweeping, mopping.

Slowly, the social worker in charge geared the daily activities of each man away from the usual hospital-oriented programs and towards chores, hobbies, and occupations suitable to an ordinary home. This required an intimate knowledge of each man's likes and dislikes, his ambitions, potentials, and limitations. Occupational therapists and volunteers helped in this program. Some volunteers adopt a patient to help him develop a hobby, and later, visit the patient in his new home when he is placed in the community. This aids the patient in his transition, and also helps the social worker who visits patients in foster homes once a week for the first six months and biweekly thereafter; the volunteer is also a great help to the new foster mother.

By the end of the first month the patients no longer thought it strange to have their own razors, to come and go as they pleased, even to invite friends in for afternoon tea.

As spring came some became interested in flowers and the garden. Some of us wondered if the planning and planting of a garden by a patient would bind him closer to the cottage to the point that he would not want to leave. By June we had our answer, when our first real gardener turned his garden over to the care of a friend and joyfully left to go to a relative's home.

The Cottage is so cozy and the atmosphere so friendly that some feared patients would not want to leave. But the Cottage proves to patients that foster homes or their own homes can be just as good. Our patients are soon convinced of this after one or two visits to prospective homes in areas they select. They know, too, that they will be seeing the social worker every week, and that if the home does not satisfy them they may select another or return to the hospital if there is need. With the knowledge that he has "the main say" the patient gains a sense of importance and returning self-confidence; this, in turn, brings about a positive attitude which practically guarantees success.

Relatives, too, responded positively. Each felt his patient had greatly improved in the Cottage setting. While the thought of having the patients in their own or a foster home has proved too much for one or two, the majority have shared our planning with us.

The Cottage also serves as a model for prospective foster parents. They have all been favorably impressed and have taken with them many ideas which help in their new venture.

Patients have little use for money in the hospital because they have canteen books which serve the same purpose. After using these for many years they dislike to use cash. In the cottage they gradually get used to the idea of spending money and having it in their new wallets. At first many resist the innovation but they soon realize that the local store prefers cash to canteen coupons for the morning paper, cigarettes, or other comfort items. As he accumulates his own dollars in his own pocket, the patient soon develops a new sense of interest and responsibility. Soon we find that the man who a few months earlier took no interest in his clothing is buying a new jacket, or belt, or overcoat.

Since doctors and nurses do not make "rounds" in homes in the community, this has not been done in the Cottage. We have a physician who acts as the "family doctor." If a patient has a physical complaint the doctor is called to the Cottage if the patient is confined to bed; if he is able to walk he goes to the doctor's office. If the doctor decides that the patient can be treated in the Cottage this is done. If his complaint requires hospitalization the patient is admitted to the appropriate medical or surgical ward. The psychiatrist who approved the patient's transfer to the Cottage is constantly apprised of the patient's progress by the social worker, and this psychiatrist gives the final approval for community placement. If the patient does not respond well in the Cottage regime then the psychiatrist brings him back to the ward setting.

Over a year has elapsed since the Cottage was opened and we can quote some statistics. It must be remembered that patients selected to go to the Cottage were chosen because they presented difficult discharge problems, yet had no symptoms to prevent them from living in the community. All had lengthy periods of hospitalization. All carried a diagnosis of schizophrenia. All had residuals of this illness.

A total of 21 patients have lived in the Cottage during the past year. One has returned to the home of relatives. Eight have gone to foster homes. Three have been returned to the hospital. Of those who have gone to their own homes and foster homes, one has returned to the hospital and all others are functioning at an adequate level.

Plan Carefully Structured

The Cottage is a studied and carefully worked out plan based on sound casework principles. The patients have the feeling throughout that movement takes place only as they are prepared to accept it. They feel that they have the major say in what happens to them. Each is free to accept or reject the prospective foster homes he visits. When the social worker places a man in a foster home, he does so with a sense of security. There are no doubts or guesswork. The foster parents are fully aware of the patient's limitations, his capabilities, and his daily routine. Under the usual methods of foster care screening, the three patients who were returned to the hospital from the Cottage could easily have been placed in the community and results could have been disastrous for the patients and foster parents. In each case, in the controlled environment of the Foster Home Cottage, we have resolved these problems, which in all likelihood would have produced unhappiness and perhaps failure if they had occurred in a foster home.

The per diem cost per patient in the Foster Home Cottage is $3.27 compared with $14.39 for hospital patients. We want to make it clear, however, that the Cottage is not a domicile nor is it a cheap solution to rising institutional costs. There is no "cheap" solution to the rehabilitation of the mentally ill. Placement in the community requires professional help, plus time; these two factors cost money but the reward is great. The patient who is properly prepared for placement in the community, and who receives sound casework help contin-

uously after placement, remains in the community. Patients who are quickly worked up for discharge planning and who are not followed up after community placement soon return to the hospital they left or to another one. Of 80 patients placed from Brockton VA Hospital in homes other than their own, only 10 returned to this hospital and none was sent to any other hospital. Of these ten, four were returned for serious physical illness. We feel that this record cannot be minimized or explained away by chance. These results clearly demonstrate the tremendous value of sound casework planning and sound casework follow-up. It is the follow-up which assures the patient that he has not been abandoned. Casework in the post-discharge phase is a "doing" type and not a recording type of casework wherein the worker merely records the patient's adjustment and does nothing to help him to make a better adjustment.

Therapeutic Goals Defined

The great value of the Foster Home Cottage is that patients are placed there for therapeutic reasons after very careful work-up. When goals have been attained the patient moves on. If they cannot be attained, the patient returns to the hospital ward where the staff continues its work along other lines. As a general rule, the maximum stay of patients in the cottage is set for six months.

While it would be possible to increase the number of patients by putting more in the Cottage, this would detract from the basic idea of having the patient learn and like the idea of a foster home through demonstration. We gave considerable thought to what constituted the ideal number of patients for the Foster Home Cottage. All agreed that a home atmosphere was essential. While few homes have ten in the immediate family unit, we felt that this would be a good number to start with, and it has proved to be a good choice. The foster mother is able to know the problems of each and to give her motherly encouragement in a reassuring and unhurried way. She can cater to the needs of each so that all receive her personal attention in sufficiently large amounts to make lasting impressions. At meal time the number is not so large as to detract from the family style of serving food and discussing topics of interest at the table. With only ten patients there is a good turnover rate, and this serves to keep the purpose of the Cottage to the forefront at all times. No patient is lost and none settles down to make the Cottage his permanent home.

No patient has so far abused the full privileges he enjoys as a Cottage patient. None of the very few simple rules has been broken. Nobody has gone AWOL or even overstayed leave. There has not been one fight. There has not been one incident of intoxication or drinking in any form in the Cottage.

GIVE US OUR DAILY ANXIETY

By Dr. Whatsisname

THE IDEAL PHYSICIAN has equanimity. So said Sir William Osler and he ought to know. Equanimity: calmness of temper; evenness of mind; composure; the trait of being hard to elate or depress.

At first thought, this seems like a reasonable prescription. In a medical crisis, we expect the doctor to be cool-headed and objective, while the relatives wring their hands. There is, however, a flaw in the picture. A true healer must have some kind of emotional investment in the outcome of the case. Psychiatrists, of all doctors, must believe that. This emotional investment goes by many names: empathy, warmth, transference, rapport, sincere interest, treating the patient as a person, as a human being, and so on. Furthermore, the trait must be genuine, since sick people, like dogs and like children, are said to be skilled in detecting spurious interest.

If, then, the therapist has a genuine emotional involvement, he has to have some anxiety—using that word in its common sense, at least, if not in its technical psychiatric meaning. The patient is in trouble, and the doctor has to feel troubled about that. Treatment is uncertain, so the physician has to have anxiety about the outcome. The *dedicatio medici* which Dr. Francis Braceland called for last year is possible only when the doctor worries about his patients. There is no real dedication without anxiety.

Psychiatry has much contact with community activities, government and the public. The conscientious psychiatrist must always be on a crusade to get better facilities for the mentally ill. But to get a head of steam behind such a campaign, you have to have a sense of mission: again an emotional involvement; again, if you choose, anxiety. So let us, if we can, strip anxiety away from our patients. But as we value our missions, let us keep a pinch of it for ourselves.

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Tulsa, Okla. — *Mid-Continent Surgical Supply Co.*
Portland, Ore. — *Physicians & Hospitals Supply Co.*
Allentown, Pa. — *Solmar Surgical Supply Co.*
Harrisburg, Pa. — *Capitol Surgical Supply Co.*
Philadelphia, Pa. — *Edward P. Dolbey & Co.*
Pittsburgh, Pa. — *Aloe Scientific*
Reading, Pa. — *Bellevue Surgical Supply Co.*
Providence, R. I. — *The Claflin Co.*
Columbia, S. C. — *Powers and Anderson*
Chattanooga, Tenn. — *Fillauer Surgical Supply Co.*
Knoxville, Tenn. — *Massey Surgical Supply, Inc.*
Memphis, Tenn. — *Kay Surgical, Inc.*
Nashville, Tenn. — *Massey Surgical Supply, Inc.*
Nashville, Tenn. — *Nashville Surgical Supply, Inc.*
Amarillo, Tex. — *Hunter Hospital Supply Co.*
Austin, Tex. — *Wilson X-Ray and Surgical Co.*
Dallas, Tex. — *Aloe Scientific*
Dallas, Tex. — *W. H. Curtin & Co.*
Dallas, Tex. — *Scientific Products*
El Paso, Tex. — *Denver Fire Clay*
Fort Worth, Tex. — *Cary-Taylor Corp.*
Fort Worth, Tex. — *Terrell Supply Co.*
Houston, Tex. — *W. H. Curtin & Co.*
Houston, Tex. — *W. A. Kyle Co.*
Lubbock, Tex. — *Hunter Hospital Supply, Inc.*
Waco, Tex. — *Curtis Surgical Supply Co.*
Salt Lake City, Utah — *Surgical Supply Center*
Richmond, Va. — *Southern Medical Supply Co.*
Seattle, Wash. — *Aloe Scientific*
Seattle, Wash. — *Scientific Supplies Co.*
Spokane, Wash. — *Physicians & Surgeons Supply Co.*
Charleston, W. Va. — *B. Preiser Co., Inc.*
Milwaukee, Wis. — *Roemer-Karrer Co.*
Honolulu, T. H. — *McKesson & Robbins, Inc.*
Honolulu, T. H. — *Von Hamm-Young Co.*

GARDENING PROJECT ACTIVATES REGRESSED PATIENTS

By A. J. ERICKSON, JACK ALSBURY
and R. F. HOFFMANN
Fergus Falls State Hospital, Minnesota

DURING THE SUMMER of 1956 we decided to use vegetable gardening as an activation program for regressed patients. Before that, only the "better" patients—about 100 of them each summer—had been assigned to work in the vegetable garden. Although the work is considered therapeutic, the primary emphasis had been on garden production.

For the activation project, however, the stress was placed on cultivating the patients' interest rather than the garden's harvest. All patients who failed to respond to occupational, recreational or simple industrial therapy were assigned to the garden project. One hundred and thirty women and 122 men—approximately 12 per cent of the hospital population—were thus selected.

We chose gardening because a large number of patients could participate, working in the sunshine, and since most of our patients had lived on farms they were familiar with vegetable gardening. The patients would be engaged in a useful pursuit, one in which they could see the fruits of their labor.

Since the purpose of the activity was to awaken patients' interest, we maintained a ratio of one employee for every ten patients, so that the patients would get sufficient individual attention. The employees assigned had to exercise patience, understanding and guidance, particularly since some of the patients could not tell a vegetable plant from a weed.

Because of insufficient personnel, we sent patients to the garden only 3 days a week. Mixed groups of men and women went to the garden on alternate days. To lend continuity to the project and to permit the aide to observe the changes in his patients, we kept the same employees on the project during the entire summer.

Most of the patients were enthusiastic about working in the garden. Many patients expressed interest in seeing the growth of the vegetables. We still hear comments of pride from patients when vegetables which were canned from this project are served at meals.

Of the 252 patients on the program 45 are now employed in various hospital industries. (None had previously been able to perform such assignments.) Twenty patients, who had previously been unable to do the simplest of ward tasks, even mopping floors, now are capable ward workers.

Our results have encouraged us to experiment further with gardening as an activation technique. This summer we will have some groups consisting of hyperactive patients and regressed patients. Other groups will consist of in-contact and out-of-contact patients. Perhaps heterogeneous grouping is more therapeutic than homogeneous grouping.

Our future plans also call for advancing patients from simple to more complex tasks. This plan could be followed until the patient has reached the maximum level of accomplishment, perhaps in an industrial assignment.

Public Education By Phone

An unusual and effective method of public education, which could be adapted by mental hygiene societies, is being used by the Vermont Alcoholic Rehabilitation Commission. A telephone recording service was installed in Burlington to inform problem drinkers and their concerned relatives that the Commission is prepared to help them. Those who respond to newspaper advertisements advising that "help is as near as your telephone" by dialing the number given, hear a one-minute recorded message. The message offers advice and encouragement for helping the alcoholic with his problems and directs the listener to seek professional advice through the Commission "at no cost and in strict confidence."

The message, which is different each day of the week, is available on two separate telephones lines. After the first month of operation (November 1956) when 200 calls a day were received, the volume of calls dropped to a steady average of 25 a day. Although at first many of the calls were from pranksters and the merely curious, nearly 100 bona fide contacts were made with the Commission in the first three months.

The telephone service costs about $50 a month to operate, not counting the cost of advertising, script writing and other incidental expenses. The success of the Burlington experiment has encouraged the Alcoholic Rehabilitation Commission to plan extending the service to other cities in the state where it has offices.

Judges and Agency Workers Discuss Hospital Procedures

Nearly a hundred county social workers, probate judges and members of the county social welfare boards, in the Osawatomie State Hospital (Kansas) district attended an all day session at the hospital. The meeting was held to acquaint the newly elected probate judges with the admission and discharge procedures and to review for the county social workers the diagnostic and therapy programs at the hospital.

Mr. Frank Long, Executive Secretary of the Kansas State Board of Social Welfare, pointed out that the reduction of waiting lists, proper screening of admissions, greater number of patients admitted, helped and discharged could not have been accomplished without the assistance and close cooperation with the county social welfare agencies. Particularly valuable, Mr. Long emphasized, is the part played by these agencies in assisting the probate judges in determining commitments. But even more important is the help that they give discharged patients in readjusting when they return to their own communities.

Interesting questions and problems were raised by the probate judges and the county welfare department representatives during the meeting, including plans for the establishment of mental health clinics in various communities. Several sound ideas were suggested by the group on how mental health could be promoted through community activities.

EUGENE J. PAWL
Staff Assistant

ADMINISTRATIV
Feature
Of The Month

Should State Hospitals Stay in the Farming Business?

By GRANVILLE L. JONES, M.D., Superintendent and A. C. YOPP, Director of Administration
Arkansas State Hospital, Little Rock

In Arkansas, the State Legislature said *No* after a legislative committee study showed that farming operations at Arkansas State Hospital were losing money, undermining patient and employee morale and serving no therapeutic purpose. The authors tell why they are glad their hospital is discontinuing its farms.

THE MENTAL HOSPITAL FARM has been accepted throughout the years as a necessary adjunct to patient care. As a result, most State mental hospitals are surrounded with vast acreages of farm and pasture land with huge herds of dairy cattle, swine and other animals. Many, in addition to producing feed for animals, grow and process large quantities of food for human consumption.

It is perhaps fair to say that these operations were necessary during the period in our history when communication and transportation facilities were inadequate. Moreover, when society demanded that the mentally ill be shut away from the community, many types of employment were necessary to keep able-bodied and perhaps non-psychotic patients occupied. This was compatible with the existing culture and social structure. But mental hospital practices must change to conform to present-day social and cultural developments.

Since World War II mental hospitals have literally opened their doors to the outside world. The general public is beginning to accept the fact that the mentally ill can be cured and returned to their rightful place in society. With the advent of new therapies, certain basic changes have taken place in the hospital community itself. The make-up of the hospital population has changed from one with a high percentage of able-bodied patients to one with a relatively high percentage of elderly people and others with physical disabilities, with a relatively small number of acutely psychotic individuals whose stay in the hospital will probably be 30 to 90 days.

Thus, it is not difficult to understand why the number of patients who can be assigned to farming activities is rapidly declining. The hospitals no longer have an unlimited source of cheap labor. This, in turn, has brought about a change in methods practiced by the mental hospital farm. Employed personnel replace patients to a great extent in order to maintain production economically. The farm is no longer designed to provide therapy for patients; it has become a commercial enterprise in which mechanized farming is practiced exclusively.

"Paper Profit" Unrealistic

Yet the mental hospital farm still exists in many hospitals and those responsible for its operation, as well as administrative officials of the hospital, sometimes become over-zealous in their efforts to show a farm profit. Small wonder, then, that some resort to questionable practices, such as adding water to the milk supply or leaving vegetables in the field for additional growth until the quality is impaired, but crediting themselves with prices prevailing in the local markets for high-quality products. It is even suspected that the few patients assigned are sometimes required to work long hours seven days a week, to help show a paper profit.

This may be because of pressures exerted by the general public through the legislature, or it can be to satisfy individuals attached to the hospital by providing them with an activity which might be termed a hobby. In either case, the possibility is ever-present that purchases of farm equipment will take priority over other types of purchases because the planting must be done, the crops must be cultivated, the cows must be milked, and the harvest must be gathered. It appears to the writers that when such a condition exists, it is certain that patient care will suffer.

Most mental hospitals, especially those deriving their support from the State's general revenue, are under constant surveillance by the general public. Most of them are large in size, making it almost impossible for the Superintendent and his aides to know at all times what is going on. Thus, it is not surprising that things happen out on the farm which cause embarrassment to the administration because of unpleasant publicity. The writers believe that most State mental hospitals have suffered considerable damage in their public relations because of distasteful publicity arising from incidents on the farm.

Last year a legislative committee investigated the operation of Arkansas State Hospital. Although this committee had many nice things to say about the hospital, it was most critical of the farming operations. The dairy herds were infested with mastitis and there was evidence of gross waste of feed and other properties. It was even charged that a number of cattle were killed through the improper use of insect poison.

Such things, of course, get back to the patients and their families. They no longer have confidence in the milk supply furnished from the dairies; nor are they content to eat vegetables grown in the garden, when they read in the papers that salad greens have been served covered with plant lice. These things reflect on pa-

tient care and create a climate not conducive to a successful treatment program.

The State Hospital Board, the Superintendent and the Business Administrator met with the Legislative Committee on several occasions to discuss and study ways and means of improving the situation at this hospital. It was rewarding to learn that these legislators were very well informed on methods of treatment and the general operation of the hospital, and that they were genuinely interested in seeing that the hospital is operated for the treatment of patients and nothing else. It was interesting and enlightening to hear some of the questions which they presented to the Board and to the hospital administrators. Should State mental hospitals operate a farm and if so, is it economical and will it be of benefit in the treatment program, they asked. How many patients are available for farm work? Could patients be assigned to other areas in the hospital? If they are reassigned will the new activity be of equal benefit? Just why do you need a farm when your job is to treat patients? Does the farm show a profit? If so, how is this possible when your farm employees work 40 hours a week and receive paid vacations and sick leave?

After a series of meetings the hospital was able to make a recommendation concerning the farming operations. Many new buildings and much equipment were needed both in the hospital and on the farm. There were not sufficient funds available in general revenue to provide these needs. The farm properties were very valuable and would probably bring in sufficient money to supplement other revenues and accelerate the building program.

Cost Accounts Found Misleading

A complete study revealed that the farms were costing $299,772 a year to operate, while the actual value of products consumed amounted to $274,229—a loss of over $25,000 per annum. Yet the cost accounting systems reflected huge profits from these operations. These cost accounts did not take into consideration that personnel assigned to other departments in the hospital were there primarily because the farm existed. For example, the maintenance, dietary, transportation and supply departments required additional personnel because of farm activities. There was even a bookkeeper in the business office who did nothing but figure farm profit and loss. Other charges not reflected in the cost accounts reports were revealed. Some of these were utilities, social security taxes, personal injury claims, administrative costs, office supplies, and transportation, and maintenance and operation of equipment not charged directly to the farm.

The report to the committee also included data concerning quality of farm products as compared to those purchased from commercial sources and what might be the expected reaction from patients and employees if served food products in which they had complete confidence.

Another point was that the hospital had been disposing of garbage by cooking and feeding it to swine. It was pointed out to the legislative group that extensive changes in our procedures and facilities would be necessary to comply with good sanitation practices if this continued. If we disposed of garbage by grinding it into the sewage system, we could avoid the need for refrigerated rooms, the messy hauling job and the inevitable problem of flies.

Another significant point brought out by the committee was that if the farms were sold, real properties in substantial amounts would be returned to the tax rolls. Moreover, purchases of foods would benefit taxpaying business firms in the State.

The Board and the hospital administration recommended that authorization be given for discontinuing the farming operations, selling the properties, and placing the money in the hospital's construction fund.

Apparently the legislative committee was thoroughly sold on the idea of getting out of the farming business. A bill was introduced authorizing disposal of the farms with proceeds going to the hospital's building fund. The bill passed both houses without a dissenting vote.

With legislative direction, we began to formulate plans for discontinuing the vast farming operations previously practiced. This has been a tremendous job and has presented many, many problems. One of the main problems has been that inherent in the cyclical phases of the farming industry. For example, feed crops are in storage for feeding the animals during the winter and early spring months and ensilage has no value unless consumed relatively soon. To sell the animals before the ensilage was consumed would have resulted in gross waste of valuable feed. By the time it is consumed the pastures are in excellent condition, and provide feed for the animals at no cash outlay. Thus, it did not seem logical to sell some thousand head of cattle while the pastures were good.

It was finally decided that the cattle would be sold during the late summer months, at the end of the good pasture season and before the harvesting of other feed crops. Dairy and beef cattle were sold at public auction during the last week of August, and purchase of the milk supply was synchronized with the sale date. Hogs have been sold when reaching marketable stage, and the final sale will be around February 1958. Other sales, such as equipment and land, are to follow the removal of all animals. It appears at this point that farm properties will show a net sale of around $1,000,000, which will enable the hospital to carry out its planned construction program during the current biennium.

Improved Morale Noticeable

It is significant that there is already considerable improvement in the morale both of patients and employees. Certainly milk coming from an inspected plant packaged in half pint waxed cartons is more desirable than that in which the patients and personnel had no confidence. The hospital is purchasing from commercial sources meats, vegetables and other items of food previously produced on the farm. All this has been done without increasing the budget for the hospital during the biennium. The only legislation required because of this radical change in operation was the provision that salary money appropriated for farm workers might be used for purchasing food and other supplies after the farming operation ceased. We are most happy with the results of this venture and believe that patient care and employee morale will be greatly improved.

Concentrated Disinfectant Found a Real Money Saver

At the Osawatomie (Kans.) State Hospital we are using a concentrated form of disinfectant which is one-sixth the cost of the liquid product previously used. The concentrate can be mixed one part to 25 parts of water, at a cost of 42 cents a gallon compared to $2.52 a gallon for the previous product.

The concentrate is called "De-O-Dis" and is produced by the United Chemical Company, 401 Delaware Street, Kansas City, Missouri.

M. MANNING, Supply Officer

Property Control Helps with Furniture Repairs

Property control at Richmond (Ind.) State Hospital is supervised by the Inventory Department, and consists of the actual moving and placing of any piece of furniture or equipment whenever necessary, as well as the keeping of a complete record of the location of each item, the description and serial numbers, original cost, date of purchase and vendor's name and address.

Before the need for property control was recognized, furniture and equipment were in bad condition. Much of the equipment was not in use because of lack of proper repair. Part of it had been stored in various out-of-the-way places and forgotten. Little attempt was made to repair or salvage any of the broken furniture, so it was eventually destroyed as junk.

During 1954 and 1955 a group of employees cleaned house. Furniture and equipment were gathered into a designated "furniture pool" from basements, attics, tunnels, out-buildings and cubby holes, where it had lain useless for months, sometimes years. Everything was carefully sorted. The good items were put to use, broken ones repaired and refinished and put into the furniture pool for future needs. Items too badly damaged for repair were torn apart. The good parts were salvaged for future repair parts, and the remainder destroyed as junk.

After completion of an inventory, a system was set up whereby permission had to be requested of the Business Administrator to move even the smallest piece of equipment the shortest distance. An inventory clerk supervises all moving to make sure that the item is in the proper place and in good condition.

Even though the system is not yet complete or perfect, the institution has already benefited from what has been done. From information on inventory cards we are able to purchase repair parts for mechanical equipment and do our own repairs. We are also able to purchase matching equipment from this information.

Our own industrial shop can now repair, refinish or reupholster furniture before it is worn or broken beyond repair. From the furniture pool we can replace broken items immediately so that our wards and departments no longer have to be without necessary furniture and equipment while repairs are being made. This phase of property control could also be classed as preventive maintenance.

EVELYN AMMON,
Inventory Clerk

How We Modernized Our Credit and Collections Department

By HELEN W. RICE, Office Manager
Arizona State Hospital, Phoenix

WHEN A PATIENT is admitted to the Arizona State Hospital it becomes the responsibility of our Credit and Collections Department to collect the fees for his treatment and care as directed by the committing court. In accordance with Arizona statutes, the county superior court of commitment is primarily responsible for fixing the amount to be paid and designating the individual who is to make the payment. The committing judge executes an order for maintenance payment based upon a certified report filed by an officer of the court who has investigated the patient's assets.

It is as logical for an individual to pay for the specialized treatment which is now available in public mental hospitals as it is for him to pay for the treatment of a physical illness in a general hospital. We believe that the responsibility for paying for the care of a relative in a public institution serves to sustain the family's interest in his welfare, and encourages them to plan for his return home. Our department's contact with the relatives during financial interviews helps them to develop a wholesome and enlightened attitude toward the illness of their relative, and we feel that this is our contribution toward effective treatment of the patient.

Revenue Sources Investigated

Our Credit and Collections Department not only submits statements and receives and receipts monies but also makes a continuing and intensive effort to follow up and investigate all sources of collection. This has been the general policy ever since the hospital began operation. However, when the Social Security law was amended to offer benefits to a larger group of people, it was imperative that the records of all of our patients be subjected to a careful review to determine their eligibility for such benefits. It was decided to incorporate in this review a careful scrutiny of each individual record for all other possible sources of revenue.

This decision necessitated a conversion of the existing filing system to one which would make all necessary information on each patient easily accessible for reference and follow-up and also easy to maintain on a day-to-day basis. In a series of conferences a Kardex form was designed which would provide space for commitment information, vital statistics, all financial information, a report of assets and liabilities (including the superior court officer's report and information received subsequent to admission), a record of correspondence and a record of admission and separation dates. The Kardex forms are housed in two mobile, desk-height cabinets which together occupy a space two feet by two and a half feet, replacing four 4-drawer filing cabinets.

The functions of the Credit and Collections Department were being handled by the writer and the maintenance collection bookkeeper. The proposed enlarged program required the addition of one individual to devote her full time to research and the filing of Social Security applications. This addition to our staff made it possible for the bookkeeper to devote all of her time to the collection and she began an intensive campaign to liquidate delinquent accounts. Her program of mailing first, second and third notice letters has resulted in the payment in full of a number of accounts long overdue. Moreover, she is now receiving monthly payments to liquidate other overdue accounts. Her enthusiasm and perseverance have shown gratifying results.

Processing of the Kardex forms means compiling information from several sources in the hospital: from the patient's folder in our department file, from the maintenance ledger card and from the clinical file in the record library. The worker extracts all pertinent data from the clinical record; she scans the medical and Social Service progress notes, the questionnaires submitted by relatives of the patients, the correspondence, the legal documents on guardianship hearings and probation of estates, the reports of County Welfare Departments—anything and everything that relates to the financial status of the patient. Her work is careful, exacting and thorough. Ten completed Kardex forms represent a good day's work. The completed form contains all information concerning the patient's eligibility for Social Security, Railroad Retirement or Veteran's benefits, and/or the possession of property or an estate. It also shows the amount of maintenance being paid and the name and address of the individual responsible for payments. Monthly payments vary, according to the ability to pay, from the established rate of $125.00 to as little as $10.00. (Last fiscal year 36% of our patient population contributed to the state's cost of their care and treatment.)

Follow-up Methods

The completed Kardex forms are reviewed by the writer. If payment is being made at the current established rate, the individual form requires no further attention. Others may need following up. This entails inquiries of the clerks of the superior courts concerning annual reports of guardians; the referral of delinquent accounts to the county attorney for assistance in enforcing collection; requests of the attorney general for advice and assistance on probation of estates; letters to guardians for information on availability of funds for payment of maintenance; or petitions to the judges of the superior courts for maintenance orders based on new information we are able to submit. This careful research has brought to light, in several cases, the possession of property which necessitated the appointment of a guardian to protect

the patient's interests. It is now routine for this department to apply for such appointment promptly.

The Kardex records are kept up to date daily by transferring from the daily census reports the date of the patient's separation from the hospital by conditional discharge, complete discharge or elopement, his return from conditional discharge (or elopement) or his readmission to the hospital.

While over 500 records out of more than 1600 are still unprocessed, the results have been good so far. Although this program of intensified research was actually begun less than twelve months ago, there was a 12 per cent increase in collections last fiscal year over the previous fiscal year. This gain was made with the valued assistance of our local Social Security and Veterans Administration representatives, the cooperation of our Social Service and Record Library personnel and of the state officials who have given of their time and experience in legal matters.

Periodic Reviews Planned

In about six months we hope to complete the conversion to the new system. A simple follow-up system is planned which will insure that applications for Social Security benefits for patients whose eligibility has been established will be filed on their anniversary date. Additionally, a periodic review will be made of the records of patients who are paying maintenance in an amount less than the current rate, to determine whether the monthly amount may be adjusted upward. Records of non-paying patients will be scrutinized annually and responsible relatives contacted to ascertain whether it is possible to begin making payments.

State law requires that legal guardians shall file a report annually with the clerk of the superior court. Inasmuch as our responsibility for our patient covers his mental and physical welfare, it must also embrace his financial welfare. To demonstrate our continuing interest in protecting his finances, anniversary dates of guardianships will be established and a request will be made annually of the clerk of the court for information submitted in the guardian's financial report.

Tips on Terrazzo Maintenance

The physical characteristics of terrazzo—which is made of marble or granite chips set into concrete—must govern the methods of cleaning it. The use of harmful materials or slipshod methods to clean it will increase the maintenance problem and cost.

Clean terrazzo is not slippery. It should not be made slippery by the use of purely surface waxes, varnish or oily preparations. (Sweeping compounds containing oil will penetrate and permanently discolor terrazzo.)

For best results, a terrazzo floor should be mopped using a good neutral soap solution that contains the least amount of soap found sufficient to loosen the dirt. Soaps and scrubbing powders containing caustic alkali should *never* be used. Each area should, of course, be mopped as often as the traffic demands, with thorough scrubbings (using a stronger cleaner if absolutely necessary) alternating as often as indicated.

After the dirt has been removed by mopping or scrubbing, the floor should be thoroughly rinsed. Dirty rinse water or cleaning solutions left to dry on the floor will form a film that dulls the appearance and natural color of terrazzo flooring.

A. J. MARELLA & R. E. TOWNE
Labor Foremen, Housekeeping Div.
VA Hospital, Brockton, Mass.

Management Course Given Supervisory Personnel

After a survey of training needs was made at Osawatomie State Hospital, the University of Kansas Extension Division conducted an intensive two-week training course of supervisors. The instruction was given by a member of the university staff with many years of experience in training supervisors in industry and business.

The course was offered to supervisors at all levels of the hospital with the stipulation that the supervisor would pay half the cost of the instruction. More than 90 people wished to take the course, but only 60 could be accommodated. Since this was conference type training, the number in each group had to be limited so that maximum participation in discussions and problem solving could be achieved.

The topics covered were: Management Principles and Human Relations; What Workers Want out of the Job; What are Good Relations; Successful Supervision; Improving Personal Management; The Supervisor and Public Relations; Cooperation—How the Supervisor Can Gain and Maintain It; Maintaining Discipline; Logical Thinking as Applied to the Solution of Grievances; Supervisors' Problems.

EUGENE J. PAWL
Staff Assistant

Landscape Student Improves Ground Care

Pontiac (Mich.) State Hospital does not have a qualified landscape man on its staff and because of this the grounds have not had effective continuing care. To remedy this, contact was made with Michigan State University and a junior student in landscape architecture was hired for the summer.

This student has worked with the groundsmen teaching them proper pruning of bushes, trees and general maintenance procedures. In addition, he has laid out various areas for long range planning, set up a recommended list of bushes and trees for a nursery at the hospital, and helped improve the morale of the grounds staff since they have confidence in his ability.

Hiring the summer student cost around $850; the hospital received many times value in return. It is hoped in the future that students in other areas will be available to the hospital, creating good job experience for the student as well as benefiting the hospital.

GERALD BAX
Business Executive

Preventive Maintenance Plan Revised for Greater Efficiency

A critical review of our preventive maintenance program was recently completed at Brockton (Mass.) VA Hospital. The survey, which studied operations during the year ending November 30, 1956, produced some conclusive figures on the utilization of maintenance personnel. It showed that there was considerable duplication of work, numerous telephone call-backs, and little fixed individual responsibility. As a result of these findings, a new system of work assignment was instituted in January 1957.

The workload of each building was assessed on a percentage basis so that the work could be divided equally among the six preventive maintenance workers. Each man was assigned to a specific group of buildings and made responsible for the preventive maintenance in those buildings. Although one man might have more buildings in his care than another, he would not, under the percentage system, have a greater workload.

To each group of buildings was assigned a number on our Doctors' Paging System so that ward personnel could quickly contact the preventive maintenance man in case of an emergency. A memorandum was issued to all personnel of the hospital informing them of the new system and urging their cooperation.

The new system has proved highly successful in bringing about greater efficiency and morale among the preventive maintenance personnel and in giving better service to the hospital.

KENNETH F. JOHNSON, Supervisor
Bldgs., Maintenance & Repair
VA Hospital, Brockton, Mass.

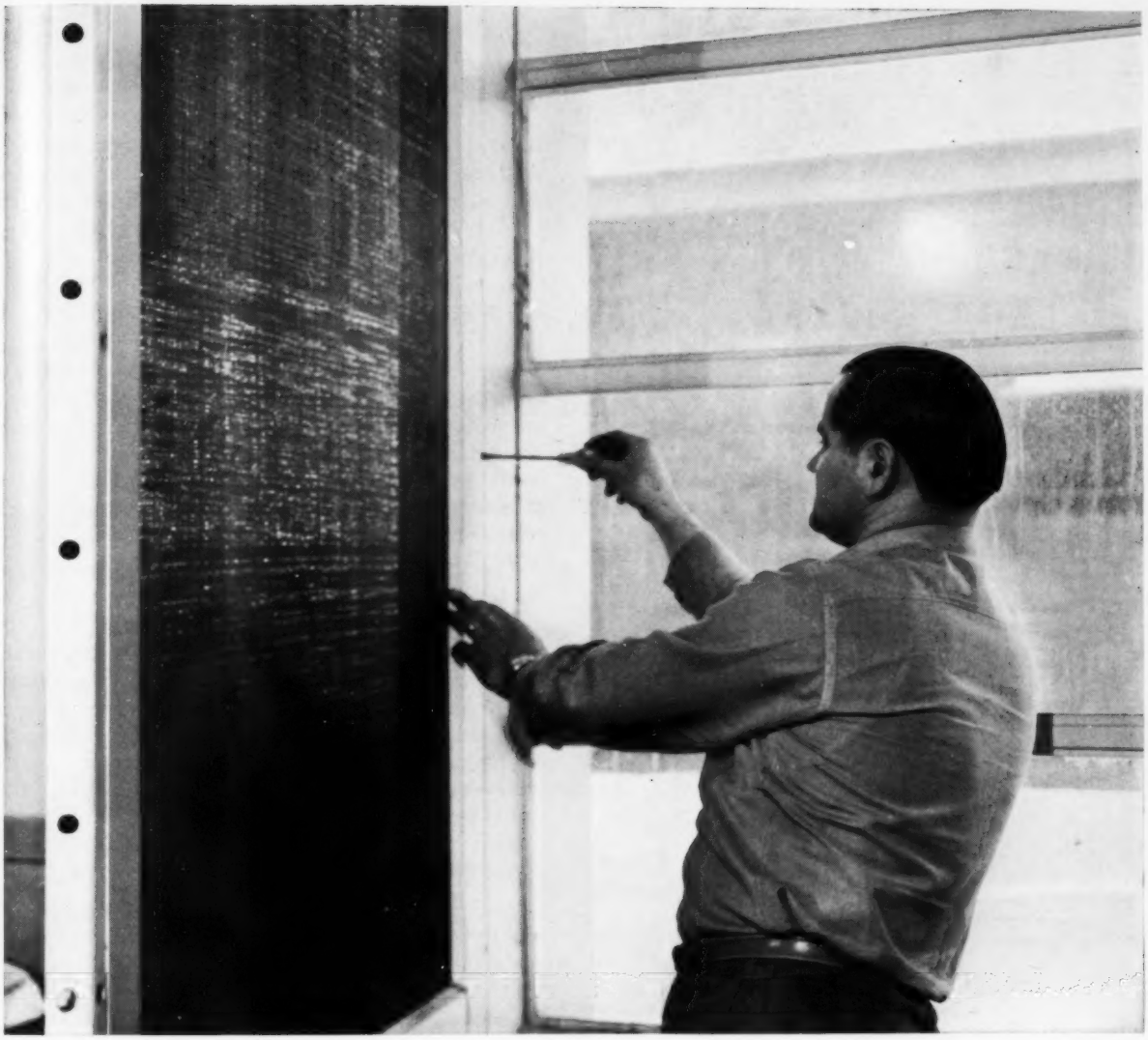
Distinctive Rag Supply Made from Old Clothing

A few years ago it was not unusual to find the windows of Enid State School, Oklahoma, being washed with a child's Sunday shirt or a brand new bath towel!

To prevent such improper usage and wastefulness, all items of clothing or linen are checked off each cottage inventory only by the Supply Officer or the Clothing Supervisor. Each cottage puts torn or damaged items on a special shelf where they remain until authorization is received to discard them.

Discarded items then go to the clothing room where buttons, elastic, etc., are removed and items usable for rags are sent to the laundry to be dyed blue. The blue rags are stored in the clothing room until needed. They are furnished in sufficient quantity so that everyone has an ample supply.

ANNA T. SCRUGGS
Superintendent



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APA and AIA

announce the planning of

MENTAL HOSPITAL

DESIGN CLINICS

The first of a series of two-day *Mental Hospital Design Clinics* under the joint auspices of the A.P.A. and the American Institute of Architects, is now in the planning phase and may be held in January. The program and exact dates will be announced in due course.

The Clinics are an outgrowth of the A.P.A. Architectural Study Project. They will provide opportunity for architects, psychiatrists, administrators, engineers, technical personnel in state government offices and the like to collaborate with distinguished experts on specific technical problems of mental hospital design, construction and equipment.

Participation in the *Design Clinics* will be by invitation only, after a review of the applications received. Membership will be limited to allow free discussion and full participation. A program announcing the membership and the problems to be considered will be mailed a month or more in advance to a select list of persons to whom the subject matter would be of particular interest. Approximately thirty of the applications will be accepted in the order received.

The Clinics, each scheduled to last two days, will be devoted to various specific problems, such as the design of general hospital psychiatric units; fireproofing; the use of color as a therapeutic measure; remodeling and redecorating old buildings; heating and ventilation; food services; furniture design and manufacture and the like. Specialized consultation from distinguished experts in psychiatry, mental hospital administration, architecture, engineering, hotel management, furniture manufacturing and design, interior decorating, and other relevant fields will be available as required.

Each problem to be considered will be presented briefly by not more than three people who will show the plans and describe how they were developed. The presentation will then be discussed by all members of the clinic and the faculty of consultants. It is believed that this open discussion will bring out the latest thinking both in architecture and psychiatry in such a way that important guidelines can be defined.

The first clinic in January will be financed by the Architectural Study Project, which is made possible by a grant from the U. S. Public Health Service, National Institute of Mental Health. A fee of from $50 to $100 will, however, be charged for succeeding clinics to defray expenses and honoraria for the faculty. It is hoped that a clinic will be scheduled about every six weeks through the spring of 1958.

Dr. Charles E. Goshen of the Architectural Study Project would welcome expressions of interest and suggestions for projects which would make suitable clinic topics. Please write to him in some detail at the American Psychiatric Association, 1785 Massachusetts Avenue, N. W., Washington 6, D. C.

DORMITORY UNIT

FARIBAULT STATE SCHOOL AND HOSPITAL

Faribault, Minnesota

Architects: HAARSTICK LUNDGREN AND ASSOCIATES, INC.
St. Paul, Minnesota

Publication of material in this section is financed by a grant from the U. S. Public Health Service

PLANNING A DORMITORY UNIT FOR THE MENTALLY DEFICIENT

By LOUIS R. LUNDGREN
Haarstick Lundgren and Associates Inc., St. Paul, Minnesota

DEPRESSING, COLD, AND FOREBODING too often describe the housing provided for the mentally deficient. Often these buildings also are inefficient from an operational point of view. While most of the recent buildings for housing the mentally deficient show marked improvement in functional organization, they still leave room for considerable improvement in terms of domestic atmosphere.

The 1955 Minnesota Legislature appropriated over $2,000,000 for additional facilities at the Minnesota State School and Hospital for the mentally retarded in Faribault. This appropriation included two 100-bed dormitory buildings, one for male patients, and another for female patients. When our firm was retained for architectural services we felt a deep sense of responsibility at being given an opportunity to participate in the Minnesota mental health program because it is quite apparent that from an architectural point of view, many difficult and challenging problems exist in this particular area of design.

Most authorities will agree on the two major objectives in providing a desirable environment for mentally retarded people: 1.) The environment should be as intimate and domestic as possible so that the normal home atmosphere from which the patient has been removed can be simulated; 2.) It is necessary that residence facilities for these people be organized in the most efficient and functional manner possible in an effort to keep the cost of their care from being excessive.

During the research stage of our work, a critical stage in which the success or failure of any building program is most often determined, it was stated both by Dr. Dale C. Cameron, Director of Medical Services of the Minnesota Department of Welfare and Dr. E. J. Engberg, Superintendent of the institution, that both of these principles were essential objectives.

As our research activity progressed it became apparent that these two basic objectives opposed each other in several ways. For example, an intimate residential character is accomplished in buildings of small size while the most economical approach to efficient function indicated rather large dormitories. The limited nursing and professional staff available to the institution seemed to necessitate a large congregate facility in which one or two staff members could supervise and care for large groups of patients.

Considerable time was spent by our staff in analysis of the dormitory units that had been built at other state institutions not only for the mentally deficient but also for the mentally ill. Careful studies were made of the existing administrative procedures at the institutions with particular emphasis on patients' routines.

It was decided that at Faribault the 100 patients to be housed in the building should be divided into smaller, more intimate groups. The ultimate scheme resulted in a patient distribution of four 24-bed wings and two suites of four isolation rooms each. In order to utilize most effectively the supervisory staff available, the basic design of the "double-cross" plan type was selected for the dormitories. This basic plan type while not new has much to commend it since a high percentage of patients are infirm. It has been proven in hospital design to be an efficient nursing unit.

The basic plan concept demanded some special adaptation. We placed dining facilities between two legs of the cross, because it is one of the few functions which do not require a high degree of nursing station supervision and could therefore be decentralized. The interior court was created as an intimate space which will be in constant use by the dormitory residents. We then oriented the day rooms, isolation rooms, and other important rooms directly onto the court. The plan, as shown, affords ready access for the dormitory residents to utilize the court, still allowing good observation and excellent security for patients' outdoor activity without the necessity of a fenced enclosure. The two basic crosses were angled to open the front of the building, thereby creating more openness to the approach and an improved outlook from each of its many wings. To achieve a better sense of shelter and so that patients will have more of a feeling of home instead of an institution, low pitched roofs were used. Wide, low overhangs on most of the principal wings give the building a more intimate scale.

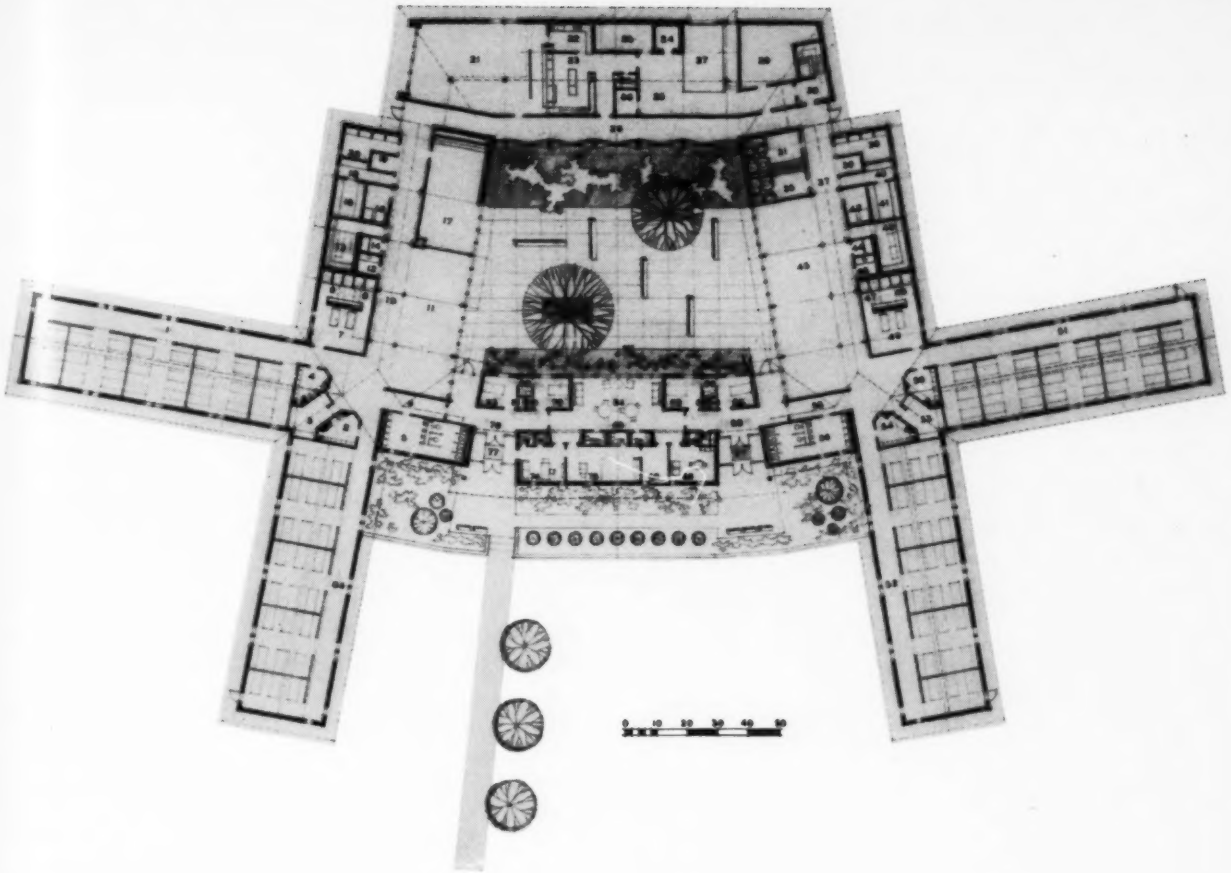
Practical vs. Aesthetic Considerations

There is another strange paradox between the basic objectives which were considered essential in the design of the dormitories. In general, institution dormitories, especially for this type of patient, must of necessity be built of materials that are very durable, easily cleaned, and require low maintenance. While such materials are absolutely necessary in most areas, very few of them convey a feeling of warmth, friendliness and intimacy. They are cold and institutional in appearance, highly reflective of sound and unlike materials commonly used in residential work. However, where we found it necessary to use such materials we tried by color, texture, proportion, etc., to ease their usual institutional effect.

It is desirable that all lighting, acoustical treatment, heating devices and apparatus be arranged inconspicuously and wherever possible, in an inaccessible position to avoid damage by and to patients. The floors in the major portion of the dormitories contain radiant heat. The ventilation and additional booster heating are arranged overhead.

The landscaping and exterior spaces were planned to enhance not only the exterior but also the interior environment by providing attractive views at many places throughout the building. We were also concerned with permitting a judicious amount of sunlight into the building without undue glare.

Construction of the buildings is expected to be completed early this summer.



Key to the Floor Plan

1 24 Bed Ward (84 x 26)
2 Patients Clothing Storage
3 Nurses Station (8 x 16)
4 Patients Clothing Storage
5 Patients Toilet Room (26 x 12)
6 Corridor
7 Patients Tub Room (17 x 15)
8 Patients Gang Shower (8 x 9)
9 Patients Gang Shower (8 x 9)
10 Corridor
11 Patients Day Room (19 x 45)
12 Enema Room (7 x 5)
13 Utility Room (9 x 15)
14 Janitors Closet
15 Linen Storage (9 x 12)
16 Soiled Linen (8 x 12)
17 Class Room (17 x 33)
18 Linen Storage (17 x 7)
19 Wheel Chairs
20 Mending and Storage
21 Dining Room (42 x 27)
22 Dishwashing
23 Kitchen (28 x 19)
24 Garbage Room
25 Trash Room
26 Receiving Dock
27 Truck
28 Corridor
29 Storage
30 Stair
31 Women's Lockers
32 Women's Toilet
33 Women's Shower and Dressing
34 Men's Shower and Dressing
35 Men's Toilet
36 Men's Locker
37 Corridor
38 Mending and Storage (17 x 8)
39 Wheelchairs
40 Linen Storage (17 x 6)
41 Linen Storage (9 x 11)
42 Soiled Linen (8 x 11)
43 Utility Room (10 x 16)
44 Janitors Closet
45 Patients Day Room (20 x 61)
46 Enema Room (7 x 5)
47 Patients Shower (8 x 10)
48 Patients Shower (8 x 10)
49 Patients Tub Room (17 x 13)
50 Patients Clothing Storage
51 24 Bed Ward (84 x 26)
52 24 Bed Ward (84 x 26)
53 Nurses Station (8 x 16)
54 Patients Clothing Storage
55 Corridor
56 Patients Toilet Room (26 x 12)
57 Vestibule
58 Corridor
59 Separation Room (12 x 10)
60 Patient Toilet
61 Patients Closet
62 Patients Closet
63 Separation Room (12 x 10)
64 Visitors Room (29 x 16)
65 Corridor
66 Storage
67 Janitors Closet
68 Barber Shop (15 x 11)
69 Patients Waiting Room (9 x 11)
70 Women's Toilet Room
71 Toilet Room
72 Men's Toilet Room
73 Clinic (24 x 11)
74 Office (15 x 11)
75 Storage
76 Toilet
77 Vestibule
78 Corridor
79 Separation Room (12 x 10)
80 Patients Closet
81 Patients Closet
82 Patients Toilet
83 Separation Room (12 x 10)
84 24 Bed Ward (84 x 26)
85 Toilet Room
86 Storage

Book Review

ROLE RELATIONS IN THE MENTAL HEALTH PROFESSIONS. By Alvin Zander, Arthur R. Cohen and Ezra Stotland. University of Michigan, 1957. 210 pp. Price $4.50.

Staff members of the Research Center for Group Dynamics at the University of Michigan have focused their attention upon "the psychiatric team." For this study, 156 psychiatrists, 165 clinical psychologists, and 159 psychiatric social workers were subjected to a standardized interview. In addition, the literature was searched for statements concerning attitudes between the three disciplines.

Since the book will give rise to considerable discussion, argument and possible criticism among members of the various professions whose attitudes it attempts to describe, this reviewer has given a summary of the book rather than a critical review.

In recent years, the authors indicate, changes in the functions of professionals within the team have affected the way they work together and the way they perceive each other's roles. Some confusion has arisen concerning who should do what and what one should not do. Each discipline brings to the team different skills and points of view. A high value is placed upon mutual interdependence and coordination of effort. The physician's usual position of authority, age and sex differences between the three professions, clinical psychology as a "new" profession, and the traditional role of the social worker as a helper were mentioned as factors which probably affect intergroup attitudes.

More equality of status within the team is needed, while at the same time differences in areas of competency and responsibility must be recognized. A truly collaborative effort can take place only if people have equality of status. Persons in dependent positions are less able to communicate frankly and honestly with each other and tend to retreat behind snug professional barriers, use projections and avoid responsibility. Improving communications tends to eliminate distortions and inter-disciplinary conflicts. Each team should explore openly their inter-role difficulties and redefine their roles and functions within the group.

Psychiatrists are usually considered the "superior profession" with the adjunct therapists as subordinates. They see their role as being primarily responsible for the treatment of the sick. As such, it is their prerogative to make decisions, delegate responsibilities and direct the activities of others. Social workers and psychologists "cannot easily move toward satisfaction of professional aspirations without the help and permission of the psychiatrist." Since the psychiatrist perceives that he is looked up to and his advice is sought by the other two professions, he feels friendly toward them and wants to delegate more functions and responsibilities to them.

Psychiatrists and the Adjunct Professions

Both psychiatrists and social workers are clear regarding their position in relation to each other. Psychiatrists concede that social workers know more about family relationships, community resources and environmental influences. They often disagree regarding skills at interviewing. Conflicts between them arise if the social worker feels left out. They may complain of lack of support or that social service is not being used to the extent it should be. Psychiatrists have more cordial relations with social workers than psychologists, but find psychologists more stimulating intellectually.

Psychologists have much more difficulty in their relationships with psychiatrists than do social workers. They desire more autonomy and are more inclined to question the authority of the psychiatrist. Psychiatrists often fail to understand that psychologists can perform functions other than testing. Psychologists want to assume more responsibility for diagnosis and therapy. They expect to benefit from contacts with psychiatrists, whereas psychiatrists expect little help from psychologists. Psychologists are arrogant regarding their research ability while psychiatrists tend to emphasize their superior status, much to the annoyance of the psychologists who are very sensitive about their own status. Seventy-five percent of the psychologists interviewed felt that they were equal or superior to psychiatrists in competence and therefore should earn as much. Female psychologists are more likely to accept the authority of the psychiatrist as proper and are less likely to voice differences of opinion.

Psychologists and Social Workers

Psychologists and social workers are not a threat to each other except in so far as they are rivals for attention from the psychiatrist. Psychologists feel they possess greater knowledge and therefore should enjoy greater status. Social workers see psychologists as being on the same level as themselves. Psychologists have a great need to be looked up to by social workers, but social workers feel little need to be appreciated by psychologists.

Relations Among Peer Groups

Psychiatrists have less need for peer approval than do other members of the team. This probably results from their high status and the respect which they receive.

Psychologists are more hostile to their own group than the two other professions, but feel they must band together for power. They have a strong need to be respected by their own group but are never quite sure they are.

Social workers are more kindly disposed toward their own group than either psychiatrists or psychologists. Social workers in high positions though tend to prefer their own group and avoid contacts with psychiatrists since this reminds them of their subordinate position.

This book should be required reading for all mental health professionals. Not only should it be read, it should be chewed, digested and discussed. It is hoped that this study will be extended to cover other members of the team and the effect of inter-group relationships upon therapeutic outcome. Since this study deals with group stereotypes it is necessary to remember that members of any one profession may not fit these stereotypes.

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